

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3020

## CERTIFICATE OF DEATH

Reg. Dist. No.

03003

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>W.</b> Last <b>Allen</b>		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>About 1885</b>
9. AGE (In years last birthday) <b>About 75</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Allen</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Cornish</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records Cambridge-Md. Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>13 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 8</b> , 19 <b>61</b> , to <b>March 20</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>March 20</b> , 19 <b>61</b> , and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		ADDRESS (Street, city or town, state) <b>Cambridge, Md.</b> DATE SIGNED <b>3/20/61</b>	
PHYSICIAN'S NAME (Type) <b>John Mace Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 23, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>East New Market, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frempton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 24 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Finner</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3021

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03004

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	c. LENGTH OF STAY IN 1b <b>6 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>E.S.State Hospital</b>		d. STREET ADDRESS <b>---</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>William Jackson Ashley</b>	First Middle Last	4. DATE OF DEATH Month <b>3</b> Day <b>14</b> Year <b>61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30 1881</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Ashley</b>		14. MOTHER'S MAIDEN NAME <b>Liza Anne Elbourn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 32 0609</b>	17. INFORMANT Address <b>Records E.S.State Hosp. Cambridge, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General peritonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Perforation jejunum</b> (c) <b>Chronic brain syndrome, cerebral arteriosclerosis, psychosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Chronic brain syndrome, cerebral arteriosclerosis, psychosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>?</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bedroom</b>	20f. (City or town) (County) (State) <b>Rock Hall, Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>3/14/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar.17/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Rock Hall, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>MARRIN WILLIAM CHESTERTOWN, MARYLAND.</b>		24a. REC'D BY REGISTRAR <b>MAR 20 '61</b>	24b. REGISTRAR'S SIGNATURE <b>William S. Howard</b>

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 3023

Name of Deceased: William John Henry  
 Date of Death: 1944  
 Place of Death: Home  
 Age: 65  
 Sex: Male  
 Race: White  
 Marital Status: Married  
 Occupation: Retired  
 Usual Residence: 1234 Main St., Baltimore, Md.  
 Date of Birth: 1879  
 Place of Birth: England  
 Cause of Death: Heart Disease  
 Immediate Cause: Myocardial Infarction  
 Underlying Cause: Coronary Artery Disease  
 Contributing Cause: None  
 Manner of Death: Natural  
 Signature of Examiner: [Signature]  
 Date of Examination: 1944  
 Signature of Physician: [Signature]  
 Date of Consultation: 1944  
 Signature of Coroner: [Signature]  
 Date of Declaration: 1944

FOR STATE  
 HEALTH OFFICE  
 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
15M 9/59

3022

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03005

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOOLFORDS, MARYLAND</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>NONE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SALLIE JANE LINTHICUM ASPLEN</b>		4. DATE OF DEATH Month Day Year <b>3 31 19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 28 1876</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		12. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
13. FATHER'S NAME <b>JERMAITH LINTHICUM</b>		14. MOTHER'S MAIDEN NAME <b>SARAH WOOLFORD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>MR. GEORGE ASPLEN, CHURCH CREEK, MARYLAND.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardio-vascular, renal disease</b> DUE TO (c) <b>Arteriosclerosis generalized and cerebral</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>4 years +</b> <b>4 years +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-3-58</b> to <b>3-31</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3-29</b> , 19 <b>61</b> , and that death occurred at <b>9:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Eldridge H. Wolff</b>		22b. DATE SIGNED <b>4-3-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Eldridge H. Wolff, M.D.</b>		22d. ADDRESS <b>15 Locust St. Cambridge, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/3/1961.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>OLD TRINITY CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>CHURCH CREEK, MARYLAND.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND.</b>		25a. REC'D BY REGISTRAR <b>APR 10 '61</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	



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1  
FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 3023 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03006

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>EAST NEW MARKET, MARYLAND.</b> c. LENGTH OF STAY IN life <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>EAST NEW MARKET, MARYLAND.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>EAST NEW MARKET, MARYLAND.</b> d. STREET ADDRESS <b>NONE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MINNY KIMMEY BANNING</b>				4. DATE OF DEATH Month Day Year <b>3 28 1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/27/1888</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>GEORGE K. KIMMEY</b>			
14. MOTHER'S MAIDEN NAME <b>ELIZABETH WILLEY</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>NO</b>				17. INFORMANT Address <b>MRS. FRANK BANNING, EAST NEW MARKET, MARYLAND.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) } (c), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>3/30/61</b> DATE SIGNED Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>3/30/1961.</b> 22c. NAME OF CEMETERY OR CREMATORY <b>EAST NEW MARKET CEMETRY</b> 22d. LOCATION (City, town, or country) (State) <b>EAST NEW MARKET, MD</b> 23. FUNERAL DIRECTOR <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND.</b> 24a. REC'D BY REGISTRAR <b>APR 10 '61</b> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>							

MEDICAL CERTIFICATION

3033



1/23/88

COGNATE ASSOCIATION

1/23/88

1/23/88

1/23/88



Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3024

CERTIFICATE OF DEATH

0300

1. PLACE OF DEATH o. COUNTY <b>DORCHESTER, CO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND.</b>		c. LENGTH OF STAY IN 1b <b>6 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CAMBRIDGE MARYLAND HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>MOWBRAY</b> Last <b>BEIDEL</b>		4. DATE OF DEATH Month <b>3</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/18/1876</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>18</b> Hours <b>18</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>CHAMBERBURG, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>MRS. CALVIN STACK, CAMBRIDGE, MARYLAND.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>434.1 CONGESTIVE HEART FAILURE</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>7 MOS.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ANEMIA</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/24/60</b> to <b>3/18/61</b> , that (I) (we) lost saw the deceased alive on <b>3/18/61</b> and that death occurred at <b>7:30 P.</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>W.E. GUNBY JR</b>		22b. DATE SIGNED <b>3/20/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.E. GUNBY JR</b>		22d. ADDRESS <b>CAMBRIDGE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/20/1961.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEMORIAL PARK.</b>		23d. LOCATION (City, town, or county) (State) <b>CAMBRIDGE, MARYLAND.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 24 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CERTIFICATE OF DEATH

1908



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3025

CERTIFICATE OF DEATH

Reg. Dist. No.

03008

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>One Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b> <b>2029-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital, Inc.</b>				d. STREET ADDRESS <b>Dover Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>W.</b> Last <b>Christopher</b>				4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 22, 1941</b>	
9. AGE (In years last birthday) <b>20</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Floor Sander</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Floor Sanding</b>		11. BIRTHPLACE (State or foreign country) <b>Preston, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Earl Christopher</b>				14. MOTHER'S MAIDEN NAME <b>Hopkins Hazel E. Hopkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>W. Earl Christopher, Easton, Md., R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxic Myocarditis</b> 754.5 DUE TO (b) <b>Subacute Bacterial Endocarditis</b> DUE TO (c) <b>Bacteremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Lobar Pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>?</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/21</b> , 19 <b>61</b> , to <b>3/25</b> , 19 <b>61</b> ; that I last saw the deceased alive on <b>3/25</b> , 19 <b>61</b> , and that death occurred at <b>4:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>104 Locust St</b> DATE SIGNED <b>3/25/61</b> ACTUAL SIGNATURE <b>W. H. Flanks</b> M.D. PHYSICIAN'S NAME (Type) <b>W. H. FLANKS</b> <b>CAMBRIDGE Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 27, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Junior Order Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Preston, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>APR 3 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	

2506

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3026  
CERTIFICATE OF DEATH

Reg. Dist. No. 03010

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Larry</b> Middle <b>Darnell</b> Last <b>Dorsey</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 28, 1961</b>
9. AGE (In years last birthday) <b>0</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>12</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>New Born</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11. BIRTHPLACE (State or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lewis Nelson, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Helen Dorsey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Cambridge Hospital Records</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> (3 lbs. 1 oz.) DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>12 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Toxemia in the Mother</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 28</b> , 19 <b>61</b> , to <b>March 10</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>March 10</b> , 19 <b>61</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Eldridge H. Wolff</b> M.D. <b>March 10, 1961</b> PHYSICIAN'S NAME (Type) <b>Eldridge H. Wolff</b> <b>15 Locust Street, Cambridge, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/13/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Waugh Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert H. Wolff</b> <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 16 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. House</b>			

2067213XVI



CERTIFICATE OF DEATH

1050

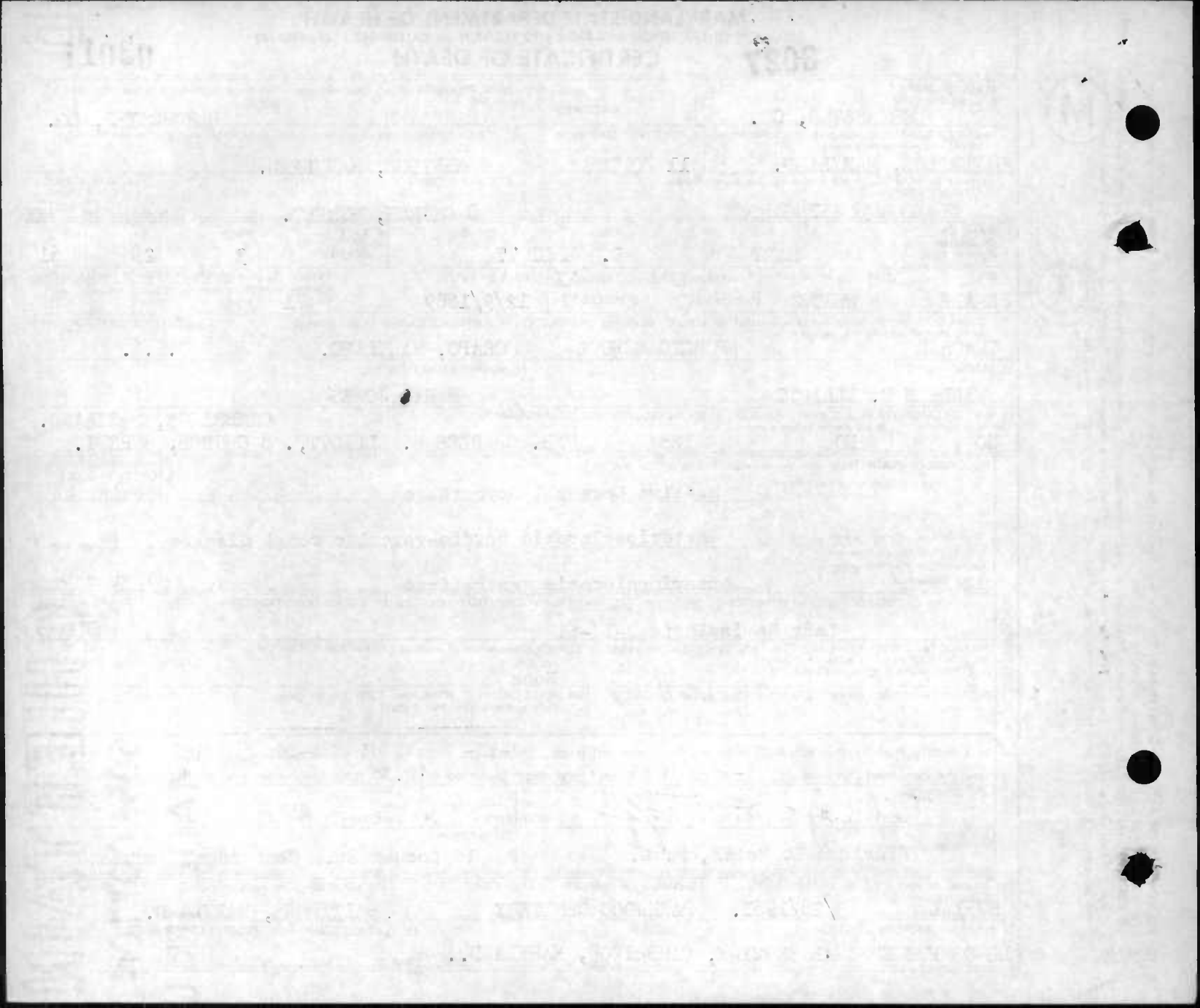
<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. MARITAL STATUS</p>		<p>8. DATE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF PHYSICIAN</p>		<p>16. SIGNATURE OF CORONER</p>	
<p>17. SIGNATURE OF JUDGE</p>		<p>18. SIGNATURE OF CLERK</p>		<p>19. SIGNATURE OF NOTARY</p>		<p>20. SIGNATURE OF SHERIFF</p>	
<p>21. SIGNATURE OF DEPUTY SHERIFF</p>		<p>22. SIGNATURE OF DEPUTY CLERK</p>		<p>23. SIGNATURE OF DEPUTY NOTARY</p>		<p>24. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>25. SIGNATURE OF DEPUTY CLERK</p>		<p>26. SIGNATURE OF DEPUTY NOTARY</p>		<p>27. SIGNATURE OF DEPUTY SHERIFF</p>		<p>28. SIGNATURE OF DEPUTY CLERK</p>	
<p>29. SIGNATURE OF DEPUTY NOTARY</p>		<p>30. SIGNATURE OF DEPUTY SHERIFF</p>		<p>31. SIGNATURE OF DEPUTY CLERK</p>		<p>32. SIGNATURE OF DEPUTY NOTARY</p>	
<p>33. SIGNATURE OF DEPUTY SHERIFF</p>		<p>34. SIGNATURE OF DEPUTY CLERK</p>		<p>35. SIGNATURE OF DEPUTY NOTARY</p>		<p>36. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>37. SIGNATURE OF DEPUTY CLERK</p>		<p>38. SIGNATURE OF DEPUTY NOTARY</p>		<p>39. SIGNATURE OF DEPUTY SHERIFF</p>		<p>40. SIGNATURE OF DEPUTY CLERK</p>	
<p>41. SIGNATURE OF DEPUTY NOTARY</p>		<p>42. SIGNATURE OF DEPUTY SHERIFF</p>		<p>43. SIGNATURE OF DEPUTY CLERK</p>		<p>44. SIGNATURE OF DEPUTY NOTARY</p>	
<p>45. SIGNATURE OF DEPUTY SHERIFF</p>		<p>46. SIGNATURE OF DEPUTY CLERK</p>		<p>47. SIGNATURE OF DEPUTY NOTARY</p>		<p>48. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>49. SIGNATURE OF DEPUTY CLERK</p>		<p>50. SIGNATURE OF DEPUTY NOTARY</p>		<p>51. SIGNATURE OF DEPUTY SHERIFF</p>		<p>52. SIGNATURE OF DEPUTY CLERK</p>	
<p>53. SIGNATURE OF DEPUTY NOTARY</p>		<p>54. SIGNATURE OF DEPUTY SHERIFF</p>		<p>55. SIGNATURE OF DEPUTY CLERK</p>		<p>56. SIGNATURE OF DEPUTY NOTARY</p>	
<p>57. SIGNATURE OF DEPUTY SHERIFF</p>		<p>58. SIGNATURE OF DEPUTY CLERK</p>		<p>59. SIGNATURE OF DEPUTY NOTARY</p>		<p>60. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>61. SIGNATURE OF DEPUTY CLERK</p>		<p>62. SIGNATURE OF DEPUTY NOTARY</p>		<p>63. SIGNATURE OF DEPUTY SHERIFF</p>		<p>64. SIGNATURE OF DEPUTY CLERK</p>	
<p>65. SIGNATURE OF DEPUTY NOTARY</p>		<p>66. SIGNATURE OF DEPUTY SHERIFF</p>		<p>67. SIGNATURE OF DEPUTY CLERK</p>		<p>68. SIGNATURE OF DEPUTY NOTARY</p>	
<p>69. SIGNATURE OF DEPUTY SHERIFF</p>		<p>70. SIGNATURE OF DEPUTY CLERK</p>		<p>71. SIGNATURE OF DEPUTY NOTARY</p>		<p>72. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>73. SIGNATURE OF DEPUTY CLERK</p>		<p>74. SIGNATURE OF DEPUTY NOTARY</p>		<p>75. SIGNATURE OF DEPUTY SHERIFF</p>		<p>76. SIGNATURE OF DEPUTY CLERK</p>	
<p>77. SIGNATURE OF DEPUTY NOTARY</p>		<p>78. SIGNATURE OF DEPUTY SHERIFF</p>		<p>79. SIGNATURE OF DEPUTY CLERK</p>		<p>80. SIGNATURE OF DEPUTY NOTARY</p>	
<p>81. SIGNATURE OF DEPUTY SHERIFF</p>		<p>82. SIGNATURE OF DEPUTY CLERK</p>		<p>83. SIGNATURE OF DEPUTY NOTARY</p>		<p>84. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>85. SIGNATURE OF DEPUTY CLERK</p>		<p>86. SIGNATURE OF DEPUTY NOTARY</p>		<p>87. SIGNATURE OF DEPUTY SHERIFF</p>		<p>88. SIGNATURE OF DEPUTY CLERK</p>	
<p>89. SIGNATURE OF DEPUTY NOTARY</p>		<p>90. SIGNATURE OF DEPUTY SHERIFF</p>		<p>91. SIGNATURE OF DEPUTY CLERK</p>		<p>92. SIGNATURE OF DEPUTY NOTARY</p>	
<p>93. SIGNATURE OF DEPUTY SHERIFF</p>		<p>94. SIGNATURE OF DEPUTY CLERK</p>		<p>95. SIGNATURE OF DEPUTY NOTARY</p>		<p>96. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>97. SIGNATURE OF DEPUTY CLERK</p>		<p>98. SIGNATURE OF DEPUTY NOTARY</p>		<p>99. SIGNATURE OF DEPUTY SHERIFF</p>		<p>100. SIGNATURE OF DEPUTY CLERK</p>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**3027** **CERTIFICATE OF DEATH** **03011**

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND.</b>				c. LENGTH OF STAY IN 1b <b>11 MONTHS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GLASGOW NURSING HOME</b>				e. STREET ADDRESS <b>8 CHURCH, STREET.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>C. ELLIOTT</b> Last				4. DATE OF DEATH Month <b>3</b> Day <b>26</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/9/1889</b>	
9. AGE (In years last birthday) yrs. <b>71</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PUBLIC SCHOOL</b>		11. BIRTHPLACE (State or foreign country) <b>CRAPO, MARYLAND.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM D. ELLIOTT</b>				14. MOTHER'S MAIDEN NAME <b>MARY JONES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>MR. CHARLES H. ELLIOTT, .. 8 CHURCH, STREET.</b>		18. CAMBRIDGE, MARYLAND.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardio-vascular renal disease</b> DUE TO (c) <b>Arteriosclerosis generalized</b>							INTERVAL BETWEEN ONSET AND DEATH <b>8 minutes</b> <b>1 year +</b> <b>1 year +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left Hemiplegia 2-13-61</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>-----</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2-13-</b> <b>19 61</b> to <b>3-26</b> , <b>1961</b> , that (I) (we) last saw the deceased alive on <b>3-26-</b> <b>19 61</b> , and that death occurred at <b>10:35</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Eldridge H. Wolff</i>				22b. ADDRESS <b>15 Locust St., Cambridge, Maryland</b>		22c. PHYSICIAN'S NAME (Type) <b>Eldridge H. Wolff, M. D.</b>	
22d. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. DATE SIGNED <b>APR 5 '61</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/28/1961.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND.</b>				25a. REC'D BY REGISTRAR <b>APR 5 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Charles L. Krawe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3028 CERTIFICATE OF DEATH 03012

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. LENGTH OF STAY IN 1b <b>35 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Centerville, Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Henry</b> First <b>Holton</b> Middle <b>Flowers</b> Last		4. DATE OF DEATH <b>March 30</b> 19 <b>61</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13 1881</b>
9. AGE (In years lost birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>William O. Flowers</b>		14. MOTHER'S MAIDEN NAME <b>Emma R. Costin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Hospital records</b>		Address <b>Eastern Shore State Hosp.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>unk</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1</b> 19 <b>53</b> to <b>Mar 30</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Mar 29</b> 19 <b>61</b> , and that death occurred at <b>6:30</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas J. Dredge</b> M.D.		22b. DATE <b>Mar 30 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>		22d. ADDRESS <b>E.S.S. Hospital, Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 1-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield</b>		23d. LOCATION (City, town, or county) (State) <b>Centerville Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. B. Butler</b>		25a. REC'D BY REGISTRAR <b>APR 4 '61</b>	
ADDRESS <b>Centerville Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

03018

CENTRAL OF DEATH

0308

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Box 4, Corbin

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205-1410

MADE IN U

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3029

CERTIFICATE OF DEATH

Reg. Dist. No. 03013

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRESTON, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN S. STATE Hosp.</u>		d. STREET ADDRESS <u>05X</u>	
3. NAME OF DECEASED (Type or print) First <u>JACOB</u> Middle <u>-</u> Last <u>GARVEY</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>H.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Novem. 6, 1899</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine mechanic.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Marion Garvey</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Lord.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>217-05-8045</u>	
17. INFORMANT <u>Records: Eastern S. State Hospital.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis with Cardio-vascular disease.</u> 241X DUE TO <u>Hemiplegia, rt.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial asthma</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>several yrs.</u> <u>11 mos</u> <u>unk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Febr. 24, 1961</u> , to <u>March 12, 1961</u> , that I last saw the deceased alive on <u>March 12, 1961</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Simon Virkutis</u>		ADDRESS (Street, city or town, state) <u>Eastern Shore State Hosp. Cambridge.</u>	
PHYSICIAN'S NAME (Type) <u>Simon Virkutis.</u>		M.D. <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/14/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CRANE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CAROLINE CO. MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry M. ...</u>		ADDRESS <u>PRESTON, Md.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

(M)

1050

CENTRAL STATE OF OHIO

1050



3030

## CERTIFICATE OF DEATH

Reg. Dist. No.

03014

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>		d. STREET ADDRESS <b>1 Pleasant St.</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>C.</b> Last <b>Gootee</b>		4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-28-1887</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Gootee</b>		14. MOTHER'S MAIDEN NAME <b>Martha Sellers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>	
17. INFORMANT <b>Cambridge Maryland Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pyelonephritis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>47 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2-1</b> , 19 <b>61</b> , to <b>3-19</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>3-19</b> , 19 <b>61</b> , and that death occurred at <b>1.05p</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Eldridge H. Wolff</b>		ADDRESS (Street, city or town, state) <b>15 Locust St.</b>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Eldridge H. Wolff, M. D.</b>		<b>Cambridge, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-21-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service, Cambridge, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 27 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

3031

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03016

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X CAMBRIDGE, MARYLAND. R.F.D.# 3.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GLASGOW NURSING HOME</b>				d. STREET ADDRESS <b>NONE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ROMAINE</b> Middle <b>B.</b> Last <b>HAMMOND</b>				4. DATE OF DEATH Month <b>3</b> Day <b>19</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/29/1873</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>CALIFORNIA, PA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JAMES K. BILLINGSLEY</b>				14. MOTHER'S MAIDEN NAME <b>ANNA HORNBAKE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>DR. EDWARD HERBOLD, R.F.D.# 3, CAMBRIDGE, MARYLAND.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL ARTERIO SCLEROSIS</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>6/15/60</b> to <b>3/19/61</b> , that (I) (we) last saw the deceased alive on <b>3/16/61</b> , and that death occurred at <b>3:30 A.</b> M., from the causes and on the date stated above.							
22a. SIGNATURE <b>W. E. GUNBY JR</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>20 MAR 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. E. GUNBY JR</b>				22d. ADDRESS <b>CAMBRIDGE MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/23/1961.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RIVERSIDE CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>ROCHESTER, NEW YORK.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND.</b>				ADDRESS <b>CAMBRIDGE, MARYLAND.</b>		25a. REC'D BY REGISTRAR <b>MAR 24 1961</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur E. Foster</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3032

## CERTIFICATE OF DEATH

Reg. Dist. No. 03017

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>				d. STREET ADDRESS <u>RD. 2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES</u> <u>HASTINGS</u>				4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>31</u> <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 2, 1874</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
13. FATHER'S NAME <u>CYRUS HASTINGS</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE WILSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u> INFORMANT Address <u>HOSPITAL RECORDS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>002X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY TUBERCULOSIS</u> DUE TO (c) <u>OVER 1 MONTH</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 HRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>FEB 17</u> , 19 <u>61</u> , to <u>MAR. 31</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>MAR. 31</u> , 19 <u>61</u> , and that death occurred at <u>4:45</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>HARRY J. CRANFORD</u> M.D. <u>E. SHORE STATE HOSPITAL - CAMBRIDGE MD</u> <u>3/31/61</u>							
ACTUAL SIGNATURE <u>HARRY J. CRANFORD</u>				PHYSICIAN'S NAME (Type) <u>HARRY J. CRANFORD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>4-3-61</u>		<u>CHARITY</u>		<u>SALISBURY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. S. Marvel Co - Belmar, Calif</u>				24a. REC'D BY REGISTRAR DATE <u>APR 4 '61</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-111111-100

3032

CERTIFICATE OF DEATH

STATE OF NEW YORK

0001

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3033

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03018

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>20yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>E.S.State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ocean City</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>JANE</b> Last <b>Hastings</b>		4. DATE OF DEATH Month <b>3</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/20/03</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Hadder</b>	
14. MOTHER'S MAIDEN NAME <b>Belle Fisher</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Records E.S.S. Hosp. Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlus ion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>10 Min.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		DATE SIGNED <b>3/7/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/10/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>	22d. LOCATION (City, town, or county) (State) <b>BERLIN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burbage</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 13 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

Continued

Received 12 May 2001

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3034

## CERTIFICATE OF DEATH

Reg. Dist. No.

03019

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Dorchester</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			c. LENGTH OF STAY IN 1b <u>21Hr. 13mins</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Vienna</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>#</u> Middle <u>2</u> Last <u>Hoffman</u> <u>1st Twin</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>26</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-25-61</u>	
9. AGE (In years last birthday) yrs. <u>21</u>		IF UNDER 1 YEAR Months <u>13</u>		IF UNDER 24 HRS. Days <u>21</u> Hours <u>13</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Donald Wayne Hoffman</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Annette Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Patricia Hoffman</u> <u>Vienna Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>3/25/61</u> to <u>3/26/61</u> , that I last saw the deceased alive on <u>3/26/61</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D. _____							
PHYSICIAN'S NAME (Type) <u>Dr. Lawrence Maryanov 136 Race Street, Cambridge, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3/27/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Vienna</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Keith S. Willozky</u>				ADDRESS <u>West New Market</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>				24c. _____			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2/067202 X00



M

VS. AISME  
5M 7/59

**MEDICAL CERTIFICATION**

22

03039

03039



MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND STATISTICS  
BIRTH, DEATH AND MARRIAGE RECORDS  
BIRTH RECORD  
Name of Child  
Date of Birth  
Place of Birth  
Sex  
Color  
Religion  
Occupation of Father  
Occupation of Mother  
Name of Father  
Name of Mother  
Name of Doctor  
Signature of Doctor  
Signature of Registrar  
Date of Registration  
Place of Registration  
City  
County  
State  
Year



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3036

CERTIFICATE OF DEATH

03021

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>2yr 5mo 16days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Md.</b> d. STREET ADDRESS <b>Springhill Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Calvin</b> Middle <b>Whitefield</b> Last <b>Jefferson</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 17, 1888</b>
9. AGE (In years lost birthday) <b>73</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief engineer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John E. Jefferson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Harvey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk.</b>		16. SOCIAL SECURITY NO. <b>214-10-8914</b>	
17. INFORMANT <b>RECORDS: Eastern Shore State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis with cardiovascular disease</b> DUE TO <b>260X</b> (b) <b>Diabetes Mellitus</b> DUE TO <b>260X</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sev. yrs.</b> <b>Sev. yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Sept. 22, 1958</b> , to <b>March 7, 1961</b> , that (I) <del>we</del> last saw the deceased alive on <b>March 7, 1961</b> , and that death occurred at <b>11P</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Simon Virkutis</b>		22b. DATE SIGNED <b>3-8-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Simon Virkutis</b>		22d. ADDRESS <b>Eastern Shore State Hospital, Cambridge, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-10-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hebron Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hebron, MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lewin R. Wilson</b>		25. REC'D BY REGISTRAR <b>Princess Anne, Md</b>	
25a. DATE <b>MAR 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

05051

CERTIFICATE OF DEATH

3030

1

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the Medical Director or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
03022									
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>E.S.State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Claiborne</b> d. STREET ADDRESS <b>20X-2</b>				
3. NAME OF DECEASED (Type or print) <b>Mary Jones</b>					4. DATE OF DEATH Month <b>Match</b> Day <b>27</b> Year <b>19 61</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/29/66</b>		9. AGE (In years last birthday) <b>94</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Robert Bromwell</b>					14. MOTHER'S MAIDEN NAME <b>Susan Anne Cooper</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>.</b>		17. INFORMANT <b>Records E.S.State Hospital</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO <b>902.0</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Compound fracture left humerus</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>11 days</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from bed in home.</b>							
20c. TIME OF INJURY Month, Day, Year <b>? Hour e.m. 3-15 19 61 p.m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Claiborne</b> (County) <b>Talbot</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <b>John Mace Jr.</b>		EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		M.D. <b>John Mace Jr.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3/27/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-30-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Heavitt Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Heavitt Md</b>			
23. FUNERAL DIRECTOR <b>S. Hambleton Harrison</b>				ADDRESS <b>Amidway</b>		24a. REC'D BY REGISTRAR <b>me</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

FOR SALE



1003

1 October

Unmarried

1 day

Unmarried

F. S. State Hospital

Wife

Female

Remarried

in home

Unmarried

Robert Brown

Robert Brown

Robert H. State Hospital

No

Confidential

1 day

Company (female) last known

1 day

Full from bed in home.

Unmarried

Home

1 day

X

1 day from home.

Unmarried

## CERTIFICATE OF DEATH

Reg. Dist. No.

03023

2038

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taylor's Island</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taylor's Island</b>			
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Purnell</b> Last <b>Jones</b>				4. DATE OF DEATH Month <b>Mar</b> Day <b>2</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1894</b>		9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address <b>Arthur W. Jones, Taylor's Island, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture Aortic Aneurysm</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/10</b> , 19 <b>60</b> , to <b>3/12</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>3/12</b> , 19 <b>61</b> , and that death occurred at <b>11 A.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. H. Hanks</b> M.D.				ADDRESS (Street, city or town, state) <b>104 Locust St. Cambridge, Md.</b>		DATE SIGNED <b>3/7/61</b>	
PHYSICIAN'S NAME (Type) <b>W. H. HANKS, M.D.</b>				<b>CAMBRIDGE MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/5/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Taylor's Island</b>		22d. LOCATION (City, town, or county) (State) <b>Dorchester County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Hanks</b>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 13 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3039

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03024

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CAMBRIDGE MARYLAND HOSPITAL</b>			d. STREET ADDRESS <b>CAVALIER, APTS.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LYMAN</b> Middle <b>M.</b> Last <b>JORDAN</b>			4. DATE OF DEATH Month <b>3</b> Day <b>15</b> Year <b>19 61</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/18/1885</b>		9. AGE (In years lost birthday) yrs. <b>75</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERINTENDANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FROZEN FOODS PLANTS ELIZABETH CITY, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS J. JORDAN</b>			14. MOTHER'S MAIDEN NAME <b>MARY COX</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>231-01-3297</b>		17. INFORMANT <b>MRS. LYMAN JORDAN, CAVALIER, APTS, CAMBRIDGE, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>?</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/14/61</b> to <b>3/15/61</b> , that (I) (we) last saw the deceased alive on <b>3/15</b> 19 <b>61</b> and that death occurred at <b>8:30 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Lawrence Maryanov</b>		22b. DATE SIGNED <b>3/15/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov, M.D.</b>	
22d. ADDRESS <b>Cambridge, Md</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/18/1961.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHRIST CHURCH YARD</b>	
23d. LOCATION (City, town, or county) <b>CAMBRIDGE, MARYLAND.</b>		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND.</b>			25a. REC'D BY REGISTRAR <b>MAR 24 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hous</b>

05084

CERTIFICATE OF DEATH

2030

2492

Generalized Atherosclerosis  
Coronary Hemorrhage

21/10/61

Dr. J. H. H. H.

21/10/61

Lawrence H. H. H.

Cambridge, Mass.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3040

03025

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (If outside corporate limits, write "RURAL" and give nearest town) <u>Hurlock</u>		c. CITY OR TOWN (If outside corporate limits, write "RURAL" and give nearest town) <u>Hurlock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nurses Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Sorin</u> Last <u>Kelley</u>		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/5/1871</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hospital Attendant - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	
11. BIRTHPLACE (State or foreign country) <u>M.D.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Kelley</u>		14. MOTHER'S MAIDEN NAME <u>Lester - (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Ms 0216 Jufft</u>	
17. INFORMANT <u>Hurlock Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation &amp; Pulmonary Edema</u> 420.0 DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>20 yrs</u> <u>25 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-1</u> 19 <u>59</u> to <u>3-7</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>3-7</u> 19 <u>61</u> and that death occurred at <u>2 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Harry B. Plummer</u>		22b. DATE SIGNED <u>3-9-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. H. B. PLUMMER</u>		22d. ADDRESS <u>Preston Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>3/10/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		23d. LOCATION (City, town, or county) (State) <u>East New Market Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leith S. Halloworthby</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 15 '61</u>	
ADDRESS <u>East New Market</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

10000

CONTINUATION OF DEATH

10000

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3041

## CERTIFICATE OF DEATH

Reg. Dist. No. 03026

1. PLACE OF DEATH a. COUNTY <b>Maryland</b> <b>Dorchester</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>				d. STREET ADDRESS <b>201 West End Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>W.</b> Last <b>Kelly</b>				4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-16-1883</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>George Washington Kelly</b>				14. MOTHER'S MAIDEN NAME <b>Mary Wesley Webster</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>714-03-4552</b>		17. INFORMANT Address <b>Mrs. Mary C. Kelly 201 West End Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma right lung with</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized metastases</b> DUE TO (c) <b>3 years</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Squamous cell carcinoma of face</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1949</b> <b>1957</b> <b>Mar 16</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Mar 16</b> , 19 <b>61</b> , and that death occurred at <b>4:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1 Locust St</b> DATE SIGNED <b>Lewis M. Burdette</b>							
ACTUAL SIGNATURE <b>Lewis M. Burdette</b> M.D.				PHYSICIAN'S NAME (Type) <b>Lewis M. Burdette</b> <b>Cambridge, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-20-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Vernon Lemmon</b>				ADDRESS <b>4611 Park Heights Ave.</b>		24a. REC'D BY REGISTRAR <b>MAR 20 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES J. JONES		M		45		1900		MASSACHUSETTS		LABORER		MARRIED		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. DISEASE OR INJURY		14. PERIOD OF ILLNESS		15. PREVIOUS ILLNESS		16. MEDICAL ATTENDANCE	
JAN 15 1950		10:00 AM		HOME		HEART DISEASE		CORONARY ARTERY DISEASE		2 WEEKS		NONE		YES	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED		21. SIGNATURE OF NEXT OF KIN		22. SIGNATURE OF CLERK		23. SIGNATURE OF JURY		24. SIGNATURE OF JUDGE	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
25. PLACE OF INTERMENT		26. NAME OF CEMETERY		27. DATE OF INTERMENT		28. TIME OF INTERMENT		29. PLACE OF INTERMENT		30. NAME OF CEMETERY		31. DATE OF INTERMENT		32. TIME OF INTERMENT	
ST. MARY'S CATHEDRAL		ST. MARY'S CATHEDRAL		JAN 16 1950		10:00 AM		ST. MARY'S CATHEDRAL		ST. MARY'S CATHEDRAL		JAN 16 1950		10:00 AM	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3042

## CERTIFICATE OF DEATH

Reg. Dist. No.

03027

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>1 hr-8 mins</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge-Maryland Hospital</u>				e. STREET ADDRESS <u>303 Choptank Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lankford</u>				4. DATE OF DEATH Month Day Year <u>March 30 19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-30-61</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. AGE (In years last birthday) yrs.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Gorman Myles Lankford</u>				14. MOTHER'S MAIDEN NAME <u>Ramona Brenda Abbott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Ramona Brenda Abbott - 303 Choptank Ave. Cambridge, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>English blastosis fetalis</u> DUE TO (b) <u>Immaturity</u> DUE TO (c) <u>770.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH 1 hr.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/30/61</u> , 19 <u>61</u> , to <u>3/30/61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3/30/61</u> , 19 <u>61</u> , and that death occurred at <u>2:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 Race St Cambridge, Md</u> DATE SIGNED <u>3/30/61</u>							
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D.				PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov Cambridge, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-31-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Lanielle Le Compte - Cambridge Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>APR 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3043

CERTIFICATE OF DEATH

03028

1. PLACE OF DEATH a. COUNTY <i>Orcheston</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Har</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>few days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cambridge Maryland</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Dona Horseman</i>		4. DATE OF DEATH <i>3/19/61</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/11/1885</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>housework</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Larrison Horseman</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ewell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>20</i>	
17. INFORMANT <i>Mr. Gilbert Pruby, Cambridge, MD</i>		Address <i>Cambridge, MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Coronary Artery Thrombosis</i> DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Lower Pneumonia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3/16/61</i> to <i>3/19/61</i> , that (I) (we) last saw the deceased alive on <i>3/19/61</i> , and that death occurred at <i>11 P.</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>W. H. Hanks</i>		22b. DATE SIGNED <i>3/23/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. H. HANKS M.D.</i>		22d. ADDRESS <i>CAMBRIDGE MARYLAND</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE THEREOF <i>3/22/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Ellis</i>		23d. LOCATION (City, town, or county) (State) <i>MD</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Willie S. Hurloughy</i>		25a. REC'D BY REGISTRAR <i>Mar 28 '61</i>	
ADDRESS <i>East New Market</i>		25b. REGISTRAR'S SIGNATURE <i>Carlton S. Hanks</i>	

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DEPARTMENT OF HEALTH

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U.S. DEPT. OF HEALTH

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3044

## CERTIFICATE OF DEATH

03029

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>6 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Glasgow Convalescent Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>Glenburn Ave., at Glasgow St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Caroline Kern</u>		First Middle Last <u>Caroline Kern Lloyd</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>March 10, 1961</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>May 9, 1871</u>	<b>9. AGE</b> (In years last birthday) <u>89</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> 11. BIRTHPLACE (County & State, or foreign country) <u>St. Paul, Minn</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>			
<b>13. FATHER'S NAME</b> <u>Arista First name Unkno Kern</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Phillipina Kopp</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>WN</u>		<b>17. INFORMANT</b> Address <u>Princeton, N.J.</u> <u>Mrs. George Tennyson, 222 B Marshall St.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arterio sclerosis</u> (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>6</u> ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>3/4/61</u> , 19 <u>61</u> , to <u>3/10/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3/10/61</u> , 19 <u>61</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Lawrence Maryanov</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> 22b. DATE SIGNED <u>3/11/61</u> 22d. ADDRESS <u>136 Race St Cambridge, Md</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Lawrence Maryanov</u>							
<b>23. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>		<b>23b. DATE THEREOF</b> <u>March 13, 61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cemetery Washington, D.C.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Kenneth P. Thomas</u>		ADDRESS <u>Cambridge, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 14 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 File # 6287 5/22/61 mh

CERTIFICATE OF DEATH

Reg. Dist. No.

03030

3045

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Church Creek</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Church Creek</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Moses</b> Middle <b>Hicks</b> Last <b>Mc Namara</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1877</b> <b>Oct. 20, 1967</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Mc Namara</b>		14. MOTHER'S MAIDEN NAME <b>Rhoda Phillips</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Marie Mc Namara, Church Creek, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia &amp; Heart Failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic (CVD)</b> (c) <b>Arterio-sclerotic Gen</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b> <b>?</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1958</b> , to <b>Mar 7, 1961</b> , that I last saw the deceased alive on <b>Mar 7, 1961</b> , and that death occurred at <b>6 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cambridge, Md</b> DATE SIGNED <b>3/10/61</b>			
ACTUAL SIGNATURE <b>James U. Thompson</b> M.D.			
PHYSICIAN'S NAME (Type) <b>James U. Thompson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/12/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Linus Road Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Dorchester County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard M. Bellamy</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 13 '61</b>	
ADDRESS <b>Cambridge, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03031

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 7 das</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>			d. STREET ADDRESS <b>305 Maryland Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Blanche</b> Last <b>Mills</b>			4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 61</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-27-75</b>	9. AGE (in years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Charlie Hatton</b>		
14. MOTHER'S MAIDEN NAME <b>Martha Kennerly</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		
16. SOCIAL SECURITY NO. <b>?</b>			17. INFORMANT <b>Mr. Walter F. Mills (Son) Delmar</b> <b>RECORDS - Eastern Shore State Hospital</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Broncho-pneumonia</b> DUE TO (b) <b>Arteriosclerotic Cardio-vascularrenal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Arteriosclerosis, marked</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 mo. +</b> <b>1 Mo. +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Beaten up by her son; sustained fract. Lft. Hip &amp; Head injury</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>?</b> a. m. <b>1/31/61</b> 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Salisbury, Wicomico, Maryland</b>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Eldridge H. Wolff</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Eldridge H. Wolff, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Cambridge, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 3, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mardella Mardela Cem.</b>	
22d. LOCATION (City, town, or county) <b>Mardella, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>DATE PR 3 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Clinton E. Hester</b>					



THIS CERTIFICATE IS TO BE  
FILED IN THE OFFICE OF THE  
STATE HEALTH DEPARTMENT  
AT THE TIME OF THE  
DEATH OF THE DECEASED



STATE OF NEW YORK  
DEPARTMENT OF HEALTH

STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		EDUCATION		OCCUPATION		MARRIAGE		RELIGION		MILITARY SERVICE		NAVY SERVICE		AIR FORCE SERVICE		ARMY SERVICE		MARINE SERVICE		COAST GUARD SERVICE		OTHER SERVICE		REMARKS																			
JAMES J. JONES		45		M		W		1910		NEW YORK		NEW YORK		NEW YORK		HIGH SCHOOL		LABORER		MARRIED		CATHOLIC		U.S. ARMY		U.S. NAVY		U.S. AIR FORCE		U.S. MARINES		U.S. COAST GUARD		OTHER		DECEASED AT HOME																					
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S COUNTRY OF BIRTH		MOTHER'S COUNTRY OF BIRTH		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S MILITARY SERVICE		MOTHER'S MILITARY SERVICE		FATHER'S NAVY SERVICE		MOTHER'S NAVY SERVICE		FATHER'S AIR FORCE SERVICE		MOTHER'S AIR FORCE SERVICE		FATHER'S ARMY SERVICE		MOTHER'S ARMY SERVICE		FATHER'S MARINE SERVICE		MOTHER'S MARINE SERVICE		FATHER'S COAST GUARD SERVICE		MOTHER'S COAST GUARD SERVICE		FATHER'S OTHER SERVICE		MOTHER'S OTHER SERVICE		REMARKS					
JOHN J. JONES		MARY J. JONES		LABORER		HOUSEWIFE		1875		1885		NEW YORK		NEW YORK		NEW YORK		NEW YORK		HIGH SCHOOL		HIGH SCHOOL		U.S. ARMY		U.S. NAVY		U.S. AIR FORCE		U.S. MARINES		U.S. COAST GUARD		OTHER		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		REMARKS													
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		EDUCATION		OCCUPATION		MARRIAGE		RELIGION		MILITARY SERVICE		NAVY SERVICE		AIR FORCE SERVICE		ARMY SERVICE		MARINE SERVICE		COAST GUARD SERVICE		OTHER SERVICE		REMARKS		REMARKS		REMARKS		REMARKS		REMARKS		REMARKS															
JANUARY 1, 1960		10:00 AM		NEW YORK		NEW YORK		NEW YORK		HIGH SCHOOL		LABORER		MARRIED		CATHOLIC		U.S. ARMY		U.S. NAVY		U.S. AIR FORCE		U.S. MARINES		U.S. COAST GUARD		OTHER		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		REMARKS															
CAUSE OF DEATH		MANNER OF DEATH		FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S COUNTRY OF BIRTH		MOTHER'S COUNTRY OF BIRTH		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S MILITARY SERVICE		MOTHER'S MILITARY SERVICE		FATHER'S NAVY SERVICE		MOTHER'S NAVY SERVICE		FATHER'S AIR FORCE SERVICE		MOTHER'S AIR FORCE SERVICE		FATHER'S ARMY SERVICE		MOTHER'S ARMY SERVICE		FATHER'S MARINE SERVICE		MOTHER'S MARINE SERVICE		FATHER'S COAST GUARD SERVICE		MOTHER'S COAST GUARD SERVICE		FATHER'S OTHER SERVICE		MOTHER'S OTHER SERVICE		REMARKS	
HEART DISEASE		NATURAL		JOHN J. JONES		MARY J. JONES		LABORER		HOUSEWIFE		1875		1885		NEW YORK		NEW YORK		NEW YORK		NEW YORK		HIGH SCHOOL		HIGH SCHOOL		U.S. ARMY		U.S. NAVY		U.S. AIR FORCE		U.S. MARINES		U.S. COAST GUARD		OTHER		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		REMARKS									
DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		DECEASED AT HOME		REMARKS									



STATE OF TEXAS

1907

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3048

## CERTIFICATE OF DEATH

Reg. Dist. No.

03033

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>	c. LENGTH OF STAY IN 1b <b>1 YEAR, 4 MO.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 CAMBRIDGE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTERN SHORE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1110 BELVEDERE AVE.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>LEONARD J. MOORE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>4</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN, 5, 1879</b>
9. AGE (In years lost birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MEAT CUTTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>GEORGE W. MOORE</b>		14. MOTHER'S MAIDEN NAME <b>MATILDA BROOKS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-14-8352</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC MYOCARDITIS</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERAL ARTERIOSCLEROSIS</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>OCT. 9, 1957</b> to <b>MAR. 4, 1961</b> , that I last saw the deceased alive on <b>MARCH 4, 1961</b> , and that death occurred at <b>6:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Ettore De Filippis</b> M.D. <b>EASTERN SHORE STATE HOSP.</b> PHYSICIAN'S NAME (Type) <b>ETTORE DE FILIPPIS</b> <b>CAMBRIDGE, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 7, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thomas</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 14 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

~~X~~ ~~X~~  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or within 72 hours after death.

Items 18&21 Film 207 5-19-61  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03034

3049

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>5 Min.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishops Head.</b>			
f. STREET ADDRESS <b>1</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Morris</b> Last <b>Morris</b>				4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 6 - 1894</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster house</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM E. MORRIS</b>				14. MOTHER'S MAIDEN NAME <b>ALLIE REDMAN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Records Cambridge Hospital</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>/Drowning/ Coronary atherosclerosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>/Fell from wharf into water./</b>			
20c. TIME OF INJURY Month, Day, Year <b>1.40 3-8-61</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Wharf-Fishing Bay Crocheron Dor.</b>		20f. (City or town) (County) (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Mace Jr.</b>				M.D.			
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MARCH 11</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CHURCH HILL</b>		22d. LOCATION (City, town, or county) (State) <b>CHURCH HILL MD.</b>	
23. FUNERAL DIRECTOR <b>Edgar L. Lane Church Hill, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 16 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

I

removal, and in any event

05003

2023

Dorchester

W5

Dorchester

Bishop's Head

2 min.

Cambridge

Cambridge Hospital

Marion 8

Marion 8

Joseph

April 1874

White

White

U.S.A.

Weymouth

Oyster house

labor

William F. McKie

Records Cambridge Hospital

1 hour

Self from about into water.

Water - falling from Cooper's Boat.

3-10-01

John Doe Jr.

CHURCH H. CHURCH Hill  
Church Hill  
Weymouth

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

3050  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03035

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George Washington Nichols</u>		4. DATE OF DEATH <u>3/26</u> 19 <u>61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/27/1885</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>William J. Nichols</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda Marine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Mrs. Mary Alice Beckett, Cambridge</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Myocardial failure</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/22/1961</u> to <u>3/26/1961</u> , that (I) <u>last</u> saw the deceased alive on <u>3/26/1961</u> , and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John Mace Jr</u>		22b. DATE SIGNED <u>3/27/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN MACE JR</u>		22d. ADDRESS <u>Cambridge Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/28/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		23d. LOCATION (City, town, or county) (State) <u>Harlock Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Kellough</u>		25a. REC'D BY REGISTRAR <u>APR 3 '61</u>	
ADDRESS <u>East New Market</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

03035

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND STATISTICS

CERTIFICATE OF DEATH

03035

X

X

X





TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is not necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director; Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3054

03036

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>DORCHESTER, CO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND.</b>		c. LENGTH OF STAY IN 1b <b>17 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>107 CHURCH, STREET.</b>		d. STREET ADDRESS <b>107 CHURCH, STREET.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM H. NORTH</b>		4. DATE OF DEATH Month <b>3</b> Day <b>26</b> Year <b>1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/20/1884</b>		9. AGE (In years last birthday) <b>76</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLOTHING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>		11. BIRTHPLACE (State or foreign country) <b>LAUREL, DELAWARE.</b>	
13. FATHER'S NAME <b>EDWARD NORTH</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH STEWARD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>MRS. WILLIAM NORTH, 107 CHURCH, STREET.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROSIS</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PARKINSONIAN SYNDROME</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Mace Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3/27/61</b>	
EXAMINER'S NAME (Type) <b>JOHN MACE JR.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/28/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GREENLAWN CEMETERY</b>	
				22d. LOCATION (City, town, or country) (State) <b>CAMBRIDGE, MARYLAND.</b>	
23. FUNERAL DIRECTOR <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MD.</b>		24a. REC'D BY REGISTRAR <b>APR 3 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

RECEIVED  
FEB 11 1961



2051

0303

105 CHURCH STREET, CAMBRIDGE, MASSACHUSETTS

WILLIAM H. NORTH

10/30/1951

ELIZABETH STEWARD

EDNA D. NORTH

NO. 105, WILLIAM NORTH, 105 CHURCH STREET, CAMBRIDGE, MASSACHUSETTS

WATERGATE

WATERGATE

JOHN PAGE JR.

3/21/61

IN COUNTY OF HENRY, VIRGINIA, I, JAMES H. PAGE, JR., Clerk of the Circuit Court, do hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Circuit Court of the County of Henry, Virginia.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3052

## CERTIFICATE OF DEATH

Reg. Dist. No.

03039

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KEET CECIL</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>2YRS-5 MOS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>			d. STREET ADDRESS <u>07X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ALVAH</u> Middle <u>A</u> Last <u>PRICE</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>11</u> Year <u>1961</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 5 1893</u>		9. AGE (In years lost birthday) <u>68</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FACTORY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>AMBROSE PRICE</u>			14. MOTHER'S MAIDEN NAME <u>LILLIAN DRAHE</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>212-20-7711</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL VASCULAR SYPHILIS</u> DUE TO (c) <u>CEREBRAL ARTERIO SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS.</u> <u>OVER 2 YRS</u> <u>OVER 2 YRS</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>OCT 14</u> , 19 <u>58</u> , to <u>MAR 11</u> , 19 <u>61</u> , that I lost the deceased alive on <u>MAR. 10</u> , 19 <u>61</u> , and that death occurred at <u>12 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>HARRY J. CRAWFORD</u> M.D. <u>CAMBRIDGE, MD.</u> <u>MARCH 11, 1961</u>					
ACTUAL SIGNATURE <u>HARRY J. CRAWFORD</u>					
PHYSICIAN'S NAME (Type) <u>HARRY J. CRAWFORD</u>					
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF <u>3/13/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephen's Cem.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward F. Edwards</u>		ADDRESS <u>Millington</u>		24a. REC'D BY REGISTRAR <u>MAR 15 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

Aug. 11. 1881 Cornell. Fr. June 13



3053

## CERTIFICATE OF DEATH

Reg. Dist. No. 03040

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BISHOPS HEAD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSP.</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>COMPTON</u> Middle <u>LEWIS</u> Last <u>PRITCHETT</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>15</u> Year <u>1961</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 30, 1894</u>	9. AGE (In years lost birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>66</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEA FOOD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN PRITCHETT</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN PRITCHETT LEWIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>213-18-4605</u>		17. INFORMANT Address <u>THOMAS L. PRITCHETT, BISHOPS HEAD, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UNDIFFERENTIATED CARCINOMA OF LEFT FACE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC 21, 1960</u> to <u>MARCH 15, 1961</u> , that I last saw the deceased alive on <u>MARCH 5, 1961</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>George H. Longley</u> M.D. <u>RFD 2 CAMBRIDGE, MD 3/15/61</u> PHYSICIAN'S NAME (Type) <u>GEORGE H. LONGLEY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/19/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DORCHESTER MEMORIAL PARK</u>		22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03040

CERTIFICATE OF DEATH

3023

W

1

*[Faint, mostly illegible text and lines, likely a form or ledger page.]*



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 1d, 2d, 10a, b, 11, 14, 15, 16, 17 & 22c File: 4286 5/2/61

1  
FOR STATE  
HEALTH DEPT.

M

<b>1. PLACE OF DEATH</b> a. COUNTY <b>DORCHESTER, Co. MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MD. LIFE</b> c. LENGTH OF STAY IN 1b <b>413 RACE, ST.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MD.</b> d. STREET ADDRESS <b>413 RACE, ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>BENJAMIN E. ROBBINS</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>3 6 1961</b>		<b>5. SEX</b> <b>MALE</b>			
<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10/17/1892</b>			
<b>9. AGE</b> (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>LUMBER Self Employed</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>LUMBER</b>			
<b>11. FATHER'S NAME</b> <b>JOSEPH E. ROBBINS</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>IDA V. JAMES</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>NO YES NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214-87-7045</b>			
<b>17. INFORMANT</b> <b>MRS. BEN. ROBBINS, CAMBRIDGE, MD.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <b>Dr. John Mace Jr.</b>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <b>3/7/61</b>			
<b>EXAMINER'S NAME</b> (Type) <b>John Mace Jr.</b>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>3/9/1961</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>DORCHESTER MEM. PK. CAMBRIDGE, MD.</b>			
<b>22d. LOCATION</b> (City, town, or country)		<b>22e. (State)</b>		<b>22f. (County)</b>			
<b>23. FUNERAL DIRECTOR</b> <b>LECOMPT'S FUNERAL SERVICE, CAMBRIDGE, MD.</b>		<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10321

3054



WABR 10321

DATE 27

3 Oct

5-10 PM

MALE WHITE

U.S.A.

Married

Lumber

Lumber

JOHN V. JAMES

JOSEPH E. ROBERTS



NO

Coronary occlusion

31/10/51

Dr. John Lee

Branch of 11/11/51

The sample for the service

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3055

## CERTIFICATE OF DEATH

Reg. Dist. No.

03042

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge-Maryland Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>			
				d. STREET ADDRESS <u>RFD Box 28</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robinson</u>				4. DATE OF DEATH Month Day Year <u>March 12 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7, 1961</u>		9. AGE (In years last birthday) yrs. <u>0</u> Months <u>4</u> Days <u>17</u> Min.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Thomas Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Juanita Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>John Thomas Robinson</u>		Address <u>Vienna, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity otherwise unk?</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>4 days 17 hrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 7</u> , 19 <u>61</u> , to <u>March 12</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 12</u> , 19 <u>61</u> , and that death occurred at <u>3-12-61</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3-12-61</u> DATE SIGNED ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>227 Pine St. Cambridge, Md.</u> PHYSICIAN'S NAME (Type) <u>Dr. J. Edwin Fassett</u> <u>227 Pine Street- Cambridge, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-13-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Vienna Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Robinson - Vienna, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 15 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2147339XV3



1  
FOR STATE  
HEALTH DEPT.

3056 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03044

1. PLACE OF DEATH a. COUNTY DORCHESTER, CO. MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER, CO.		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHURCH CREEK, MARYLAND.		c. LENGTH OF STAY IN 1b UNKNOWN		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HOOPERSVILLE, MARYLAND.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) STATE ROAD NEAR CHURCH CREEK, MARYLAND.			d. STREET ADDRESS NONE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) W. FREDERICK RUARK			4. DATE OF DEATH Month 3 Day 26 Year 19 61		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17/1933		9. AGE (In years last birthday) 28 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY WATERMAN		11. BIRTHPLACE (State or foreign country) HOOPERSVILLE, MARYLAND.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME HORACE RUARK			14. MOTHER'S MAIDEN NAME SUE RUARK		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES UNKNOWN		16. SOCIAL SECURITY NO. YES		17. INFORMANT MRS. HORACE RUARK, HOOPERSVILLE, MARYLAND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL INJURY 822 X DUE TO Conditions, if any, which gave rise to immediate cause (b) MULTIPLE FRACTURES OF SKULL (c) DUE TO (e), stating the underlying cause last.					
INTERVAL BETWEEN ONSET AND DEATH INSTANT INSTANT					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) DRIVER OF AUTO WHICH OVERTURNED			
20c. TIME OF INJURY Month, Day, Year 2.30 AM 3-26 19 61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) Nr. Church Creek	(County) Md.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JOHN MACE JR.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3/27/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/28/1961.		22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEM. PARK.	
23. FUNERAL DIRECTOR LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MD..		22d. LOCATION (City, town, or country) CAMBRIDGE, MARYLAND.		24a. REC'D BY REGISTRAR APR 3 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraw...	

VS. A15ME  
5M 9/60

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



05004

3038

2/17/33

INTER-KILLING THEORY

MULTIPLE FRANCHISES OF HUNTS

DRIVER OF AUTO WITH OVERTURNED

3-20-33 3-20-33 3-20-33

JOHN HALL JR.

3/28/33

EXECUTIVE JOURNAL EDITOR, CINCINNATI, OH.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the reason therefor in the space provided. This certificate is to be used for the purpose of recording the death and should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3057 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03045

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market, R.F.D.</u>		c. LENGTH OF STAY IN 1b <u>23 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market, Md., R.D.</u>	
		d. STREET ADDRESS <u>Rural</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gustav</u> Middle <u>Edwin</u> Last <u>Salkvist</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20, 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Civil Engineer</u>	
11. BIRTHPLACE (State or foreign country) <u>Stockholm, Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>168-03-4087</u>	
17. INFORMANT <u>Mrs. Melene C. Salkvist, East New Market, Md., R.F.D.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 Min.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John Mace Jr.</u> EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>3/13/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 13, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Howard</u> ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 20 '61</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

051153

U.S. AND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

# POST-MORTEM EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		SIGNS		TESTS		TREATMENT		PROGNOSIS		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		PSYCHOLOGICAL HISTORY	
FINDINGS AT AUTOPSY		GROSS FINDINGS		MICROSCOPIC FINDINGS		HISTOCHEMISTRY		IMMUNOHISTOCHEMISTRY		CYTOLOGY		BACTERIOLOGY		VIRUS		PARASITIC		TOXICOLOGY		PHARMACOLOGY		OTHER	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		INSTITUTION		CITY		STATE		COUNTRY		DATE		TIME		PLACE		REMARKS		SIGNATURE OF WITNESS		TITLE OF WITNESS	

RECEIVED  
BALTIMORE  
MAY 11 1953

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3058

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03046

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND.</b>				c. LENGTH OF STAY IN 1b <b>2 WEEKS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS, MARYLAND.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CAMBRIDGE MARYLAND HOSPITAL</b>				d. STREET ADDRESS <b>NONE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MINA</b> Middle <b>WALLACE</b> Last <b>SIMMONS</b>		4. DATE OF DEATH Month <b>3</b> Day <b>29</b> Year <b>19 61</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/29/1873</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>GOLDEN HILL, MARYLAND.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SLATER WALLACE</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH SLACUM</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>MR. ROY SIMMONS, ANDREWS, MARYLAND.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> DUE TO (b) <b>Phlebotrombosis femoral veins</b> DUE TO (c) <b>Appendicitis, ruptured, peritonitis</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>2 weeks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 18 1961</b> to <b>Mar 29 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>Mar 29 1961</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Lewis M. Burdette</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Mar 29, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lewis M. Burdette</b>				22d. ADDRESS <b>1 Locust St, Cambridge, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/31/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEMORIAL PARK</b>		23d. LOCATION (City, town, or county) (State) <b>CAMBRIDGE, MARYLAND.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND.</b>				25a. REC'D BY REGISTRAR <b>DATE APR 5 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Knaus</b>	

03028

CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3059 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03047

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>1/9/61</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Talbot</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxford</b> d. STREET ADDRESS <b>---</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elmer E. Simpson</b> First Middle Last 4. DATE OF DEATH <b>March 12 1961</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>4/27/67</b> 9. AGE (In years last birthday) <b>93</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b> 11. BIRTHPLACE (State or foreign country) <b>Illinois</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown Benjamin Simpson</b> 14. MOTHER'S MAIDEN NAME <b>Unknown Clara Seacrist</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>---</b> 17. INFORMANT <b>Records E.S. State Hospital</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> 904.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fracture neck right femur</b> DUE TO (c) <b>---</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>17 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome, senile brain disease.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>Slipped and fell in hall of hospital</b> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>4-45 2-24-61</b> Hour p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b> 20f. (City or town) (County) (State) <b>Cambridge Dor. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Type) <b>Burial</b> 22b. DATE THEREOF <b>Mar. 14, 1961</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Oxford Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Oxford Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3/12/61</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. E. Newman &amp; Son Eastern Md.</b> ADDRESS <b>---</b> 24a. REC'D BY REGISTRAR <b>---</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b> DATE <b>MAR 16 61</b>			

THE STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1903

Name of Deceased		John Doe	
Age		35	
Sex		Male	
Race		Caucasian	
Marital Status		Single	
Occupation		Teacher	
Residence		123 Main St, Baltimore, Md.	
Date of Death		Jan 15, 1903	
Place of Death		Home	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Examiner		[Signature]	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3060 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03048

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	c. LENGTH OF STAY IN 1b <b>2yr.7mo.7das.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS <b>JACKSON BOULEVARD, Gandy Ave.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>Leila Mae Somers</b>	4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1961</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1879</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John H. Lankford</b>		14. MOTHER'S MAIDEN NAME <b>Emily Bedsworth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-07-7019</b>	17. INFORMANT <b>RECORDS - Eastern Shore State Hospital</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> 904.7 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fracture neck right femur</b> (c) <b>Due to the underlying cause lost.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 mo.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found lying on floor.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5.25 p.m. 1/20/61</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	20f. (City or town) (County) (State) <b>Cambridge Dor. Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>3/29/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/31/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Harvey Bradshaw, Crisfield</b>		24a. REC'D BY REGISTRAR DATE <b>APR 3 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director for your files. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
HARTLAND STATE DEPARTMENT OF HEALTH - BATHING ONE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES J. JONES		45		M		W		1/20/02	
RESIDENCE		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
100 W. 10th St. N.Y.C.		100 W. 10th St. N.Y.C.		DISEASE OF THE HEART		NATURAL		J. J. JONES	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		DATE OF MARRIAGE	
Clerk		High School		Catholic		Married		1/15/00	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
None		None		None		None		None	
HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS	
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79 yrs.		79 yrs.		79 yrs.		79 yrs.		79 yrs.	
80 yrs.		80 yrs.		80 yrs.		80 yrs.		80 yrs.	
81 yrs.		81 yrs.		81 yrs.		81 yrs.		81 yrs.	
82 yrs.		82 yrs.		82 yrs.		82 yrs.		82 yrs.	
83 yrs.		83 yrs.		83 yrs.		83 yrs.		83 yrs.	
84 yrs.		84 yrs.		84 yrs.		84 yrs.		84 yrs.	
85 yrs.		85 yrs.		85 yrs.		85 yrs.		85 yrs.	
86 yrs.		86 yrs.		86 yrs.		86 yrs.		86 yrs.	
87 yrs.		87 yrs.		87 yrs.		87 yrs.		87 yrs.	
88 yrs.		88 yrs.		88 yrs.		88 yrs.		88 yrs.	
89 yrs.		89 yrs.		89 yrs.		89 yrs.		89 yrs.	
90 yrs.		90 yrs.		90 yrs.		90 yrs.		90 yrs.	
91 yrs.		91 yrs.		91 yrs.		91 yrs.		91 yrs.	
92 yrs.		92 yrs.		92 yrs.		92 yrs.		92 yrs.	
93 yrs.		93 yrs.		93 yrs.		93 yrs.		93 yrs.	
94 yrs.		94 yrs.		94 yrs.		94 yrs.		94 yrs.	
95 yrs.		95 yrs.		95 yrs.		95 yrs.		95 yrs.	
96 yrs.		96 yrs.		96 yrs.		96 yrs.		96 yrs.	
97 yrs.		97 yrs.		97 yrs.		97 yrs.		97 yrs.	
98 yrs.		98 yrs.		98 yrs.		98 yrs.		98 yrs.	
99 yrs.		99 yrs.		99 yrs.		99 yrs.		99 yrs.	
100 yrs.		100 yrs.		100 yrs.		100 yrs.		100 yrs.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3061

CERTIFICATE OF DEATH

Reg. Dist. No. 03049

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harlock</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fisher Nursing Home</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Preston</b>	
3. NAME OF DECEASED (Type or print) First <b>Henry b</b> Middle <b>Archie</b> Last <b>Spies</b>		4. DATE OF DEATH Month <b>Mar</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 6, 1875</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Poultry</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY <b>US</b>	
13. FATHER'S NAME <b>Wm Spies</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Barber</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-34-7654</b>	
17. INFORMANT <b>Mrs. Emma K. Spies</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Paraplegia from 7th thoracic down</b> <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Spinal cord retention</b> DUE TO (c) <b>Renal cell carcinoma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>3-20</b> 19 <b>60</b> to <b>3-24</b> 19 <b>61</b> , that I last saw the deceased alive on <b>3-23</b> 19 <b>61</b> , and that death occurred at <b>8:30 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Harry B. Plummer</b> M.D. <b>Preston Md</b> <b>3/25/61</b> PHYSICIAN'S NAME (Type) <b>DR. H. B. Plummer</b> <b>Preston Md.</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>Mar. 27. 61</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Druidridge</b> 22d. LOCATION (City, town, or county) (State) <b>Baltimore - Baltimore</b> 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>H. M. Hall</b> <b>Preston, Md.</b> 24a. REC'D BY REGISTRAR <b>MAR 28 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Charles E. Henson</b>			

CERTIFICATE OF DEATH

1000

1000-1

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. RACE White	
5. DATE OF DEATH April 10, 1954		6. PLACE OF DEATH Home	
7. TIME OF DEATH 10:30 AM		8. CAUSE OF DEATH Myocardial Infarction	
9. MANNER OF DEATH Natural		10. SIGNATURE OF PHYSICIAN J. H. HARRIS	
11. SIGNATURE OF REGISTRAR J. H. HARRIS		12. SIGNATURE OF WITNESSES J. H. HARRIS	
13. SIGNATURE OF FUNERAL HOME J. H. HARRIS		14. SIGNATURE OF BURIAL PLACE J. H. HARRIS	
15. SIGNATURE OF INTERVIEWER J. H. HARRIS		16. SIGNATURE OF REVIEWER J. H. HARRIS	
17. SIGNATURE OF APPROVER J. H. HARRIS		18. SIGNATURE OF SUPERVISOR J. H. HARRIS	
19. SIGNATURE OF CHIEF OF BUREAU J. H. HARRIS		20. SIGNATURE OF DIRECTOR J. H. HARRIS	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3062

## CERTIFICATE OF DEATH

Reg. Dist. No.

03050

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
c. LENGTH OF STAY IN 1b <b>9 days</b>		d. STREET ADDRESS <b>Asbury Section</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital, Cambridge</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>FRANCES</b> Last <b>STERLING</b>		4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/14/80</b>
9. AGE (In years lost birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months <b>80</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>John Sterling</b>		14. MOTHER'S MAIDEN NAME <b>Sara Davy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 28</b> , 19 <b>61</b> , to <b>March 9</b> , 19 <b>61</b> that I last saw the deceased alive on <b>March 9</b> , 19 <b>61</b> , and that death occurred at <b>10:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D. <b>E.S.S. Hospital, Cambridge, Md.</b> <b>3/9/61</b>			
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 12, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Methodist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons - Crisfield</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 13 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3063

CERTIFICATE OF DEATH

03051

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>15yr.6mo.12das</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> d. STREET ADDRESS <b>-</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mae</b> Middle <b>-</b> Last <b>Stevenson</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-26-98</b>
9. AGE (In years lost birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>62</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William E. Stevenson</b>		14. MOTHER'S MAIDEN NAME <b>/Nora E./ Ward Laura E. Ward</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Eastern Shore State Hospital records</b>		Address <b>Eastern Shore State Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>General Arteriosclerosis</b> DUE TO (c) <b>-</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from <b>6-1</b> <b>1957</b> to <b>3-30</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>3-28</b> <b>1961</b> and that death occurred at <b>12:03 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Ettore DeFilippis</b> M.D.		22b. DATE SIGNED <b>3-30-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ettore DeFilippis, M.D.</b>		22d. ADDRESS <b>Eastern Shore State Hospital Cambridge, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 1, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Harvey Bradshaw, Crisfield</b>		25a. REC'D BY REGISTRAR <b>APR 3 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Krasa</b>		25c. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

3063

03001

1. Name of deceased: [Illegible]  
2. Sex: [Illegible]  
3. Age: [Illegible]  
4. Date of birth: [Illegible]  
5. Date of death: [Illegible]  
6. Place of death: [Illegible]  
7. Cause of death: [Illegible]  
8. Signature of physician: [Illegible]  
9. Signature of registrar: [Illegible]  
10. Date of registration: [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03052

3064

Item 10 Film 0283 3/22/61 mb

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. LENGTH OF STAY IN 1b <b>2 yrs 24 days 7 mths</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS <b>05X-2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Annie Elizabeth Stokes</b>		4. DATE OF DEATH Month <b>Mar</b> Day <b>17</b> Year <b>1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1872</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Horsewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN L. JOURNALIN</b>		14. MOTHER'S MAIDEN NAME <b>LUCINDA BRIDGES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Hospital records Cambridge Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Arteriosclerosis</b> <b>450.0</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>unk</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from <b>July 24, 1958</b> to <b>Mar 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>Mar 17, 1961</b> , and that death occurred at <b>11:30</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>Thomas J. Dredge</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Mar 17 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>		22d. ADDRESS <b>E.S.S.H. Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 21, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Burysville</b>	
23d. LOCATION (City, town, or county) <b>Burysville Del.</b>		(State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Moulton</b>		ADDRESS <b>Baltimore</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 20 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10453

CERTIFICATE OF DEATH

1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

BP

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3066

## CERTIFICATE OF DEATH

03054

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN lb <b>25 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glasgow Convalescent Home</b>				d. STREET ADDRESS <b>114 Choptank Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Catherine</b> Last <b>Thomas</b>				4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 26, 1876</b>		9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>James Island, Dor, Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Naboth Slacum</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Barnes</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. J. Spicer Bell, Talbot Ave., Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>HYPERTENSIVE CARDIO VASCULAR DISEASE</b> (e), stating the underlying cause last. (c) <b>ARTERIOSCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-11-53</b> , 19....., to <b>3-6-61</b> , 19....., that (I) (we) last saw the deceased alive on <b>3-5-61</b> , 19....., and that death occurred at <b>12:45 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Albert E. Bunker</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-8-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALBERT E. BUNKER, M. D.</b>				22d. ADDRESS <b>MARYLAND AVE., CAMBRIDGE, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 8, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cambridge, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel R. Thomas</i>				ADDRESS <b>Cambridge, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 20 '61</b>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03055

3067

Item 9 File 6284 4-10-61 1wk

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HURLOCK, MARYLAND.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 CAMBRIDGE, MARYLAND.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FISHER NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HATTIE</b> Middle <b>J.</b> Last <b>WINGATE</b>		4. DATE OF DEATH Month <b>3</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/26/1892</b>
9. AGE (In years last birthday) <b>163 69 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARY OHIO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>AUGUST HILDEN</b>		14. MOTHER'S MAIDEN NAME <b>HILDEN BRANDT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>MRS. FRANK HENRY, CAMBRIDGE, MARYLAND.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> (c) <b>Hypertensive Arteriosclerosis/Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Bronchitis and/or Bronchiectasis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>P-16</b> , 1961, to <b>3-28</b> , 1961, that (I) (we) last saw the deceased alive on <b>March 27</b> , 1961, and that death occurred at <b>P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J. H. B. Plummer</b>		22b. DATE SIGNED <b>3/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. H. B. PLUMMER</b>		22d. ADDRESS <b>PRESTON, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/30/1961.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GREENLAWN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>CAMBRIDGE, MARYLAND.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 5 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

ALBANY, N. Y.

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IN SENATE

January 1, 1900

REPORT

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TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it may be retained for your files. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03056

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>313 High St.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>313 High St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anne</b> Middle <b>Elizabeth</b> Last <b>Woolford</b>		4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>19 61</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August. 10. 1908</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homes</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lemuel Woolford</b>		14. MOTHER'S MAIDEN NAME <b>Ivy Clash</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Carroll Hall</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>10 Mins.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>3/13/61</b> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/16/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR <b>Herbert StClair</b>		ADDRESS <b>Cambridge, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 16 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>	

MEDICAL CERTIFICATION

4298

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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CAMP, JUNE 1941



Page 4  
TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03057

3069

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Wesley</b> Last <b>Woolford</b>				4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 16, 1895</b>		9. AGE (In years lost birthday) <b>65 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Poultry Industry</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Cornish</b>				14. MOTHER'S MAIDEN NAME <b>(First name unknown) Woolford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-14-2873</b>		17. INFORMANT <b>Manie M. Woolford, Hurlock, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart of Atherosclerosis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary sclerosis, severe</b> DUE TO (c) <b>Arterio-sclerosis, gen</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b> <b>5 yrs</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1953</b> to <b>May</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Mar 5</b> 19 <b>61</b> , and that death occurred at <b>12:55 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>James W. Thompson</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>James W. Thompson</b>				22d. ADDRESS <b>Cambridge, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 10, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salem Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Near Vienna, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Trampton and Son, Federalburg, Maryland</b>				25a. REC'D BY REGISTRAR <b>MAR 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

05057

CERTIFICATE OF DEATH

1068

①

*James Robert Jones*  
*born [illegible]*  
 *died [illegible]*

*CHIEF*  
*CLERK*  
*REGISTRY*

*James Robert Jones*  
*born [illegible]*  
 *died [illegible]*